City of Detroit

Claim File Audit
Findings & Recommendations

August 1999

Presented by:

Aon Risk Services
Aon Consulting

City of Detroit

Table of Contents

Table of Contents

Page No.

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1. Executive Summary

The City of Detroit retained an audit team to conduct a comprehensive assessment of the City's workers' compensation claims management process. All aspects of workers' compensation management, through a process review and claim file audit, were evaluated. The results were compared to industry best practices for workers' compensation management.

When this audit was commissioned, the City had already begun to make positive changes in the management of work related injuries. An experienced workers' compensation claims manager has been hired, and his efforts have begun to show positive results in several areas such as: the relationship between risk management and legal, and settlement evaluations and claim file documentation. The evaluation of the City's workers' compensation management process identifies a number of opportunities to build this momentum based on the positive changes already underway.

Key Recommendations

Return to Work

The City would benefit from the development and implementation of formalized, consistent return to work policies and procedures. Some efforts have been made to return injured employees to work in modified or alternate duty positions, but formalized, consistent procedures are not clearly established and documented.

Prompt Claim Reporting

The City should consider implementing procedures to ensure timely reporting of on-the-job injuries. Timely claim reporting ensures that workers' compensation claims can be thoroughly evaluated and managed, employees will receive prompt medical care, and benefits will be effectively delivered. Industry studies have shown a direct correlation between timely claim reporting and lower claims costs ("Best Practice," Section 3-c).

Claim Duration & Cost

Presently, the City does not establish a financial value (reserve) for each claim and, therefore, an accurate accounting of the City's expected liabilities for workers' compensation claims is not known. In addition, on average lost time claims are open for 49.8 months, many with little documented activity. The City should consider a thorough review of each open claim in order to establish an anticipated financial value and a strategy for claim closure.

Adjuster Training, Experience & Caseload

The evaluation showed that the City's workers' compensation adjusters were working in a difficult situation as a result of their lack of training and experience and heavy caseloads. The City's adjusters all came into their positions with no prior experience as workers' compensation claim adjusters. In addition, no formal training program (initial or ongoing) is currently in place for adjusters.

It is recommended that the City develop and implement a formal, comprehensive training program for all adjusters to thoroughly familiarize them with all aspects of workers' compensation claim administration in the City and in Michigan. An ongoing training program should also be developed and implemented to ensure that adjusters are kept updated regarding medical and legal changes related to workers compensation.

Adjuster caseloads are also high when compared to industry standards. The City should consider an evaluation of all open claims to determine the potential for claim closure. Staffing ratios and claim volume targets should be established.

Coordination with Other Benefits

The relationship between the City's Duty Disability program and workers' compensation is not clearly defined. It is recommended that the City conduct a review of that program that results in clearly defined program guidelines, roles and responsibilities and points of coordination with workers compensation.

Claim/Litigation Process

Roles and responsibilities between the claim and legal departments should be clearly defined. Specific issues such as file control, settlement authority, and communication requirements between the two departments should be addressed. It is also recommended that the City consider a review of claim files currently handled in the legal department to gain an understanding of the process applied to manage these claims.

Summary

The evaluation of the City of Detroit's workers' compensation management process found that the City has begun to make a number of positive changes in this area. There are, however, many opportunities to increase the impact of future improvements on the City's overall claim cost and the delivery of benefits to injured and disabled employees. An accurate projection of savings associated with the recommendations contained in this report could not be provided due to the fact that the City does not currently establish financial values for open workers' compensation claims. The following next steps are being recommended:

- Conduct a review of the City's Duty Disability program
- Conduct a review of the claims currently handled by the Legal Department
- Conduct a full review of each open lost time claim to determine the anticipated financial value and to develop claim closure strategies
- Develop and implement comprehensive training programs for existing adjusters.

If the City undertakes the strategies noted above, it will develop the foundation for a cost effective, efficient system for managing work related injuries.

2. Approach and Methodology

The evaluation of the workers' compensation claims management process for the City of Detroit consisted of the following components:

- Process review
- Claim file audit

Use of these techniques provides a comprehensive overview of the workers' compensation claims management process, including key elements such as claim reporting, accident investigation and return to work.

2-a. Process Review

This phase of the evaluation included a review of all existing written policies and procedures related to the management of on-the-job injuries and illnesses. Interviews were conducted with the following personnel:

- workers' compensation claim adjusters
- workers' compensation claims manager
- risk manager
- medical director
- department safety officers
- chief assistant corporation counsel
- employees who have experienced the workers' compensation process

An interview was conducted with the Chief Assistant Corporation Counsel for the City's labor/workers' compensation section of the law department. A member of the audit team and an attorney conducted this interview. Issues specific to the litigation process currently in place in the City will be addressed in a separate section of this report.

A total of 17 people were interviewed. Interview questions were designed to gather information regarding the interviewee's understanding and perceptions of the workers' compensation claim process.

2-b. Claim File Audit

In addition to the process review, a thorough audit of a representative sample of claim files was conducted. A total of 250 claims were reviewed and the sample was stratified as follows:

- ***150 Open Claims***
  Using a standard statistical sampling assumption, the results of the first 150 open claims reviewed were so consistent and uniform that the audit team determined that review of the remaining open claims would not provide any additional value to the City.

- ***31 Closed Claims***
  This sample of closed claims was reviewed to evaluate the development and execution of claim resolution strategies.

- ***50 Claims Currently In Litigation***
  In order to evaluate the litigation management process, a sample of claims in litigation were also reviewed. This aspect of the file review consisted only of a review of the claim portions of these litigated files. The scope of the audit did not include a review of the attorneys' litigation files.

The process evaluation and claim file reviews were conducted on-site at City offices over a five-day period. The process maps and findings and recommendations, which follow in subsequent sections of this report, are based on an analysis of the information gathered through the methodology described above, and a comparison to industry best practices.

3. Process Review

Based on the information obtained through interviews, documentation review and claim file review, the current claims management process for the City of Detroit was mapped. The written process was then compared to the actual functioning process and to industry best practices for workers' compensation claims management. The process maps are included as Appendix A.

Several key issues were uncovered, unique to the City of Detroit, that arise from systemic/institutional processes within the City. These issues are detailed in this section of the report. If the City chooses to address these issues and to implement subsequent recommendations, the City can save time, effort and money. A higher level of service for City employees and facilitation of timely return to work are additional results of implementation.

3-a. Return to Work

Findings

- The City's return to work programs do not appear to be well defined. Although some departments do provide modified or alternate duty work, it does not appear that the existing formalized program is in place within any department. A "favored work" program does exist within the mayor's office, but guidelines for this program are also unclear. We were advised that employees could remain in the "favored work" program for up to two years.
- It was also been brought to our attention that under the previous administration injured employees were not allowed to return to work unless the employee was 100% recovered from the work-related injury. Historically, this practice has severely hampered the Claim Department's return to work efforts. While this policy is no longer in force, its effects still linger; a number of cases reviewed were initially opened during that period.

Best Practices

- *Employers taking a best practice approach in this area make every effort to return injured employees to work in modified or alternate duty jobs as soon as it is medically feasible to do so.*
- *Formalized transitional duty policies are documented and communicated to all employees and managers.*
- *Program guidelines are clearly documented, including the roles and responsibilities of all parties.*

Return to Work Recommendations

1. The City has made improvements in previous return to work practices. It is recommended that at this juncture the City develop and implement a formalized return to work program for all departments.
2. The policy should include specific timeframes for reevaluation of the work capability status of each injured employee, and the procedures for transitioning employee's back into their previous positions.

3-b. Duty Disability & Return To Work Efforts

Findings

- ▲ The relationship between workers' compensation and Duty Disability was not clear. Information provided to the audit team revealed that in some cases Duty Disability personnel had the authority to override a decision made by the Claim Department regarding return to work.
- ▲ The audit team was informed that even if the Claim Department and the physician agree that an injured person can return to work, the Duty Disability review physician can overrule that decision. It was not clear, however, under what specific circumstances the Duty Disability Department can override decisions made by the workers' compensation claim staff. This practice is an impediment to the facilitating safe and timely return to work.

Best Practices

- ■ *In situations where employers pay benefits from multiple sources for the same disability, the definitions of disability and authority for disability determination are clearly defined. Often, due to the differences in definition of disability (e.g., statutory workers' compensation and employer provided supplemental accident disability benefit), an employee may be eligible for one type of benefit, but not necessarily the other.*
- ■ *Eligibility for benefits is not necessarily interdependent. A determination of eligibility for one type of benefit does not always mean automatic eligibility for a related benefit.*
- ■ *Specific communication protocols are established to ensure that information is exchanged in a timely and thorough manner.*

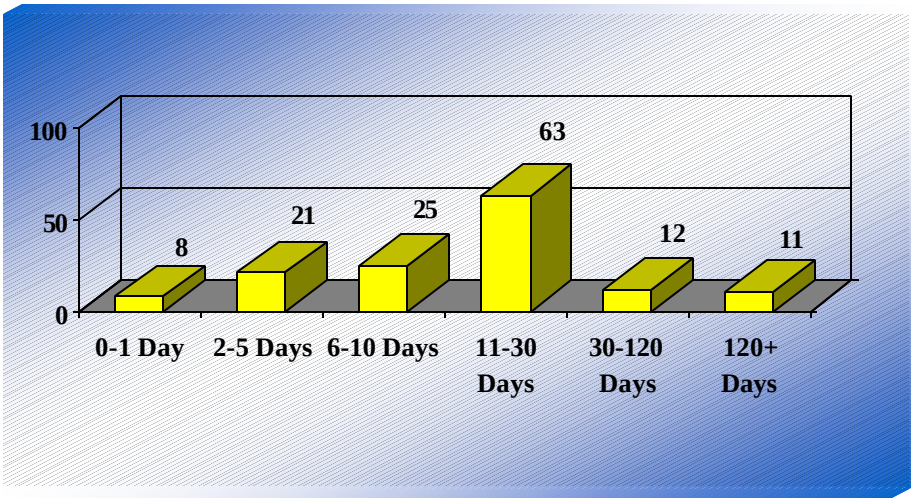
Duty Disability & Return To Work Recommendations

1. In order to obtain a complete picture of the relationship between workers' compensation and Duty Disability, it is recommended that an evaluation of the Duty Disability program be undertaken to:
    - Clarify the relationship between the Duty Disability and workers compensation.
    - Clearly define the roles, responsibilities and scope of authority for each department.
2. Develop and implement a system of checks and balances to ensure that each department operates within the defined scope of authority and that necessary communication occurs.

3-c. Late Claim Reporting

Findings

- In 37% of the claims reviewed by the audit team, the date that the claim was reported to risk management was not documented. Of those claims where the date was clearly indicated, the average reporting lag time was 24 days. Six claims were reviewed in which the lag time exceeded 700 days. These six claims are excluded from the lag time figure noted above. If these claims are included, the average lag time for the sample reviewed is 124 days. 63 claims, or 30% of the claims reviewed, were reported between 11 and 30 days from the date of injury.



- Interviews indicated that in many instances the Claim Department is first notified of a claim by a provider when the bill is submitted for treatment rendered in connection with a work-related injury.

  The team also learned that an injury report requires three levels of approval to risk management, serving to further slow the claim reporting process.

Best Practices

- *Claims should be reported within 24 hours of injury. Studies have demonstrated that early claim reporting increases the effectiveness of claims management and reduces cost. A study conducted by Kemper Insurance Company of 122,959 claims closed in 1997 found that those claims reported within 10 days of injury had an average cost of $9,172 and those reported over 10 days from the date of injury had an average cost of $13,833 (34% higher!). The study also found that litigation rates were lower for claims reported within 10 days of injury.*
- *There are several aspects of the Michigan workers' compensation law that can become an issue if the claim is not reported promptly. Michigan law provides for employer direction of care for the first 10 days of an injury. If the Claim Department is not notified of the claim within that timeframe, the ability to direct care to providers with proven return to work results is lost. Michigan law also requires that lost time payment be made on the 14th day of disability. To comply with this aspect of the law, claims must be reported prior to the 14th day of disability.*

Claim Reporting Recommendations

1. Develop and implement a method of early claim reporting to ensure that all claims are reported to Risk Management within 24 hours of injury.
2. Develop and provide training for all necessary personnel, including department management, first line supervisors and safety officers.
3. Eliminate the requirement for three levels of departmental approval prior to claim submission. Each supervisor should be held responsible for reporting workers' compensation claims on the same day that they are notified of an injury.

3-d. Allocation of Claims Costs

Findings

- ▲ At this time there is no formal process for allocation of claims costs to different departments. This is done on an informal basis but is not part of departmental performance evaluations each year.

Best Practices

- ■ *Employers using best practices in this area have developed and implemented some type of formal departmental cost allocation system. This results in increased departmental responsibility for injury prevention and management.*

Allocation of Claim Costs Recommendations

1. The City should consider developing and implementing a formal system of cost allocation for workers compensation. This would serve to increase departmental accountability and awareness, thus helping to reduce accidents and control costs.

3-e. Adjuster Training & Experience

Findings

- ▲ Many of the claim adjusters do not have professional training and/or experience in workers' compensation claims management. Informal on-the-job training is provided, but there was no evidence of any formal, professional training program for new adjusters or retraining/refreshment for experienced adjusters.
- ▲ The audit team was informed that the adjuster pay scale is more aligned with a clerical function, rather than a professional function. The current pay scale hampers the risk manager and claim manager when they attempt to fill open positions with experienced personnel.

Best Practices

- ■ *Insurance companies, third party administrators and employers who self-administer their workers' compensation claims generally hire a mix of experienced workers' compensation adjusters and new adjusters.*
- ■ *Formal training is provided to all adjusters, with a general orientation for everyone hired, and a more comprehensive program for adjusters with no prior experience. This ensures that all claims are handled in a consistent manner, following established policies and procedures.*
- ■ *Average annual salaries for experienced adjusters in Michigan are currently in the range of $40,000 - $50,000.*

Adjuster Training/Experience Recommendations

1. Develop an ongoing formal workers' compensation training program for all current adjusters.
2. The program should include the medical and legal aspects of workers' compensation claims management, as well as a mechanism through which the adjusters can keep current on changes in Michigan law.
3. The City should also consider hiring an experienced workers' compensation claim adjuster to handle complex claims and serve as a resource to the existing claims staff.
4. It is also recommended that the City review adjuster salary scales and make any adjustments necessary to align the salaries with the current marketplace in Michigan.

3-f. Adjuster Union Affiliation

Findings

▲ Claim adjusters are members of the same union to which some other City employees belong. This creates an inherent conflict-of-interest for the adjusters. It is important to note, however, that while no indication was found in any of the files reviewed that the situation affected management of the claim in any way, the potential for conflict of interest, or perceived conflict of interest exists.

Best Practices

■ *Self-administered employers do not generally include claim adjusters in labor unions.*

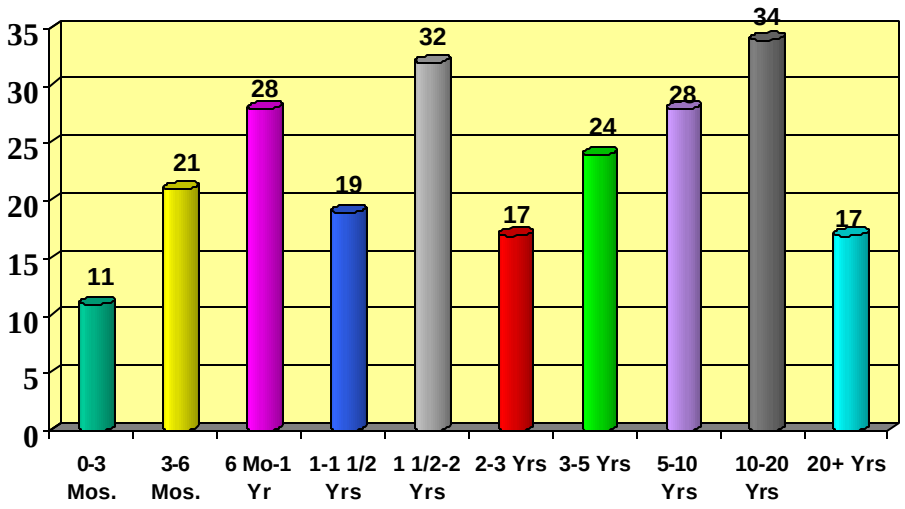
Adjuster Union Affiliation Recommendations

1. The City of Detroit should review the adjusters' union affiliation and, if possible, change it. Changing the union affiliation would also present an opportunity for assessment of the claim representatives' job performance on merit. This would serve to establish and maintain a high level of professional competence for all adjusters resulting in quality, cost efficient claims management services for the City and its employees.

3-g. Adjuster Caseload

Findings

- ▲ The caseload for the claim adjusters ranges between 300 and 582.
- ▲ Adjusters handle both medical only and indemnity cases.
- ▲ Adjusters are assigned to handle claims for specific departments within the City.
- ▲ It is also of note that claims in the sample of files reviewed were open an average of 49.8 months. 103 claims (45%) of the claims reviewed were open for 3 years or longer. 38 claims (16.5%) of those reviewed have been open between 10 and 20 years. Strikingly, 17 claims (7.4%) remain open 20 years or longer.



Best Practices

- *Best practices indicate that it is more efficient to have adjusters designated to handle only one type of claim. Adjusters typically handle only lost time, medical only or litigated claims.*
- *Experienced claim adjusters handle the more intricate cases while less experienced adjusters handle those that are less complex.*
- *Typical adjuster caseloads range from 135-175 for lost time, and 200-300 for medical only, depending on the level of adjuster experience.*

Adjuster Caseload Recommendations

1. The City should review all open lost time and litigated claims to determine if closure strategies can be developed and implemented to reduce both claim adjuster backlog and cost.
2. Service teams should be designated according to department, and adjuster caseloads should be redistributed within the team, according to level of adjuster experience and claim type.
3. The risk manager also indicated that the Claim Department might add a designated litigation representative. This is an excellent idea, which should be instituted as quickly as possible. It is strongly recommended that this individual have significant previous experience in managing litigated workers' compensation claims.

3-h. Relations with the Legal Department

Findings

- ▲ When a claim is in litigation it is handled completely by the City's Legal Department with essentially no involvement of the claim adjuster. The adjusters are not aware of the status of a claim in litigation, and have not historically had input into the settlement value of the claim. Further, neither the adjusters nor the claim manager have any authority to settle routine claims.
- ▲ The estrangement of the two departments appears to be a historical outgrowth from prior years, when there was less emphasis on managing workers' compensation claims. Some evidence was seen that the relationship is beginning to improve as a result of recent efforts by the Risk Management and Claim Departments.

Best Practices

- ■ *During litigation, the claim adjuster typically retains primary responsibility for the file, with the attorney handling the litigation. Extensive teamwork is required to affect a positive claim and legal outcome. Most routine claim settlement is done by claim adjusters, with legal staff used for consultation related to specific issues, or in litigated claim situations.*

Legal Department Relations Recommendations

1. Develop procedures for management of litigated claims, which define roles and responsibilities of both claim and legal staff.
2. Schedule regular roundtable discussions on litigated claims in which both claims and legal staff participate.
3. Develop guidelines for routine settlement of claims by adjusters, incorporating levels of settlement authority for both the adjusters and the claim manager, who has extensive workers' compensation claim experience.

4. FILE REVIEW

A total of 231 workers' compensation claim files were individually reviewed by a member of the audit team. Of the files reviewed, 150 were open claims, 31 were closed claims and 50 were open claims in litigation. The results of the review of the first 150 open claims were so consistent and uniform, that the review team felt that further efforts would be redundant and would not provide any additional value to the City

The claim files reviewed were each read in their entirety by a member of the audit team. The team member then completed an audit sheet on the file that had been reviewed. The claim adjuster was consulted if a question arose on the case. Once all of the claims in the sample were reviewed, the review team identified common trends within each audit review category. The results were compared to the standards recognized as the "best practices" of claim handling for workers' compensation claims.

The file audit findings are discussed below, and compared to the "best practices" of workers' compensation claim handling. Comments are made regarding each category evaluated by the auditors. Recommendations for changes are suggested that could strengthen the present system of handling claims, resulting in enhanced administrative efficiency, improved service for injured employees, and reduced costs.

4-a. Reserves

Findings

- ▲ Based on the sample of claims reviewed, it was found that the workers' compensation claims are not individually reserved, that is, an estimate of the financial impact of each claim is not done.

Best Practices

- ■ *Each claim is initially analyzed to estimate the overall cost. The analysis takes into account numerous factors including: the severity of the injury sustained, the estimated recovery period, the type, duration and cost of medical treatment that will be rendered, and the estimated amount of indemnity (lost time) payments that will be made. A financial value is then established for the claim, which is the reserve. The reserve represents the amount that must be set aside (reserved) to pay the claim to conclusion.*
- ■ *Individual claim reserves are adjusted in accordance with changing claim circumstances. For example, if the injury is less serious than originally thought, the reserve might be reduced. However, if surgery is determined to be necessary on a case that was originally considered to be minor, the reserves would have to be increased. Payments made on the claim reduce the amount of money held in reserve.*

Reserve Recommendations

1. It is recommended that open claims be reviewed and analyzed, and a reserve reflecting the anticipated claim exposure established.
2. A claim database should be developed, and claim reserves entered into the database. This would permit ready access by Risk Management to claim financial information on an ongoing basis. Reserves for all open claims would represent the total estimated outstanding liabilities associated with workers' compensation claims for the City of Detroit.

4-b. Timely Three Point Contact

Findings

- ▲ Based on the sample of claim files reviewed, it does not appear that initial three-point contacts (see description below under best practices) are made on workers' compensation claims. If such contacts are made, they are not clearly documented in the sample of claim files reviewed by the audit team.

Best Practices

- *It is best practice that within 24 hours of the receipt of the claim the claim adjuster makes contact with:*
  - *The injured worker*
  - *The injured workers' supervisor*
  - *The injured workers' doctor*

  This allows the claim adjuster to assess the injury, verify compensability, determine the initial course of treatment and set a realistic reserve for the claim.
- *In Michigan, prompt three-point contact is particularly key to the issue of medical care direction. Michigan law permits employer direction of care for only the first 10 days from the date of injury. Prompt three-point contact allows the claim adjuster to identify potential claim resolution issues early on in the claim, and to establish a framework for return to work and a plan for immediate claim resolution.*

Three Point Contact Recommendations

1. Establish and train a standard of three point contact within 24-hours of initial receipt of claim. All adjusters should be fully trained in the process of initial claim contact and claim investigation.
2. After an initial period of training has elapsed, the City should also consider incorporating the timeliness and quality of adjusters' initial contact into their performance evaluation.

4-c. Timely & Thorough Compensability Investigation

Findings

- ▲ Review of the claim file sample did not show evidence that any claim investigations are performed to determine compensability. Some claim files reviewed did show evidence of some investigation done at the scene by supervisors, but most often the initial report of the claim is taken at face value by the claim adjusters.

Best Practices

- ■ *The adjuster performs an initial investigation of the claim in order to ensure compensability. The claim adjuster establishes the facts of the accident and determines the compensability of each claim.*
- ■ *The initial investigation includes gathering the facts of the accident, conducting interviews with the employee, supervisor and witnesses to the occurrence that resulted in the injury.*
- ■ *The compensability decision, along with the rationale for the decision, including information gathered during the investigation, is clearly documented in the claim file.*

Compensability Investigation Recommendations

1. It is recommended that a basic compensability investigation be conducted on each workers' compensation claim. While many claims do not need a great deal of investigation to determine compensability, it is important that an initial investigation be completed so that the adjuster has a clear picture of the accident facts, and can determine compensability with certainty. Adjusters should be thoroughly trained to conduct compensability investigations.
2. It is also recommended that the compensability decision and the rationale for the decision be clearly documented in the claim file. Compensability issues and a clear plan of action to address these issues should also be clearly documented.
3. If necessary, the information gathered during the course of the compensability investigation can be used in the litigation process to support the City's assertion that the claim was not work-related. It is also recommended that the adjusters periodically visit field locations to speak with supervisors and become familiar with the jobs being done in the field.

4-d. Index Bureau Check Obtained

Findings

- ▲ None of the sample claims reviewed indicated a filing with the Index Bureau.
- ▲ There was no evidence that claims are researched internally for multiple claims by the same employee.
- ▲ Some evidence was found of employees with multiple injuries from multiple occurrences that needed to be managed concurrently.

Best Practices

- ■ *Most insurers and claim-handling entities file claims with the Index Bureau. The Index Bureau establishes a central countrywide database containing all claims of which the Bureau is notified. This database provides information to adjusters regarding how many claims a person has filed, the type of claim, with what entity was the claim filed, and more.*
- ■ *Index Bureau filings are not limited to workers' compensation claims. Therefore, researching claims filed with the Index Bureau provides a complete record of an employee's current and previous claim activity. This information can assist the adjuster with identification of pre-existing medical conditions, potential fraud and abuse, as well as subrogation and Second Injury Fund opportunities.*
- ■ *It is also a best practice to maintain an internal claim database, which allows the adjuster to access previous or concurrent claims filed by an employee. Often, this is a function of the claim adjudication or RMIS system. This practice serves many of the same purposes as an Index Bureau check, and allows concurrent claims to be managed in a coordinated manner.*

Index Bureau Recommendations

1. It is recommended that the City institute a practice of filing all claims with the Index Bureau. It is our understanding that the Legal Department already has this capability, and we would suggest that an arrangement be considered to expand the capability to the Claim Department.
2. It is also recommended that the City consider developing and maintaining an internal claim database in order to access internal claim history for employees. This database would also be used to determine whether or not concurrent claims exist and would facilitate coordinated management of these claims.

4-e. Subrogation Investigated

Findings

▲ The sample of claims reviewed did not demonstrate consideration of subrogation potential by the claim adjusters. The only evidence of subrogation noted in the files reviewed occurred in those instances where the City was notified of litigation against a third party by an attorney retained by the claimant for that purpose.

Best Practices

■ *One of the issues typically analyzed by claim adjusters during initial and ongoing claim investigation is the potential for subrogation. As the facts of the accident are gathered, they are reviewed to determine the possibility that a third party caused or contributed to the injury of an employee. If it is determined that this situation exists, partial or full recovery can be legally pursued. Such recovery reduces the amount paid on the particular claim.*

Subrogation Recommendations

1. In is recommended that the process of subrogation review be incorporated into the adjusters' initial and ongoing claim investigation.
2. The City should develop and implement training for all adjusters in identification of subrogation opportunities.
3. Both the claim adjuster and the manager should review each case for subrogation opportunities.
4. If such an opportunity is identified, an action plan for recovery of claim dollars should be developed and implemented. If necessary, these opportunities should be brought to the attention of the Legal Department to ensure that the City's right of recovery is protected.

4-f. Second Injury Fund Investigated & Pursued

Findings

- ▲ The sample of claim files reviewed indicated no evidence of investigation of Second Injury Fund possibilities.

Best Practices

- ■ *Second Injury Funds (SIF) are established by states to limit an employer's liability for injuries that aggravate pre-existing disabilities. The SIF is contacted when a workplace injury combined with a prior disability creates a worse or total disability. The employer takes responsibility for the new injury; the SIF pays the difference in benefits between the new injury and the worse or total disability.*
- ■ *The employer or claims administrator is responsible for filing notice with the Second Injury Fund, and providing the required documentation of the injury. It is an opportunity to reduce the amount the employer has to pay for a claim resulting from an aggravation of a previous injury.*

Second Injury Fund Recommendations

1. It is recommended that claim adjusters be fully trained in the procedures and guidelines for obtaining recovery from the Michigan SIF.
2. Each claim should be initially reviewed for SIF potential by the adjusters and the claim manager.

4-g. Light/Modified Duty Investigated

Findings

- A review of the claim file sample revealed that there is no consistent practice for returning injured employees to either transitional or full duty. The City does have a "favored work" program, which provides light duty work in the mayor's volunteer office, but was unable to identify clear guidelines for inclusion in the program, evaluation of employees while they are participating in the program, and transitioning employees back to permanent jobs.
- It should also be noted that it is perceived that some departments are willing to return employees back to "light duty" while others are not.
- The files reviewed also revealed that Functional Capacity Examinations are being used to identify employee's functional capacities in order to facilitate return to work.

Best Practices

- *It has been demonstrated that employees recover from work-related injures faster, and the cost of claims is lessened, when employees are brought back to work as soon as medically feasible. Studies have shown that a well-managed return to work program can save up to 30% of workers' compensation costs (Washington Business Group on Health). Often, such return to work is in a modified or alternate transitional duty job for a limited period of time, until the employee is functionally able to perform their own job.*
- *Written return to work guidelines outline the roles, responsibilities and action steps for all parties including employees, claim adjusters, department heads, supervisors, and treating physicians. Written job descriptions are developed which detail the essential functions and physical requirements of each job in order to assist physicians in determining the employee's functional ability to perform a specific job. Implementing the return-to-work program is a coordinated effort between the claim adjuster, the supervisor, the treating physician and the injured employee.*

Light/Modified Duty Recommendations

1. A return-to-work program is one of the key elements in containing workers' compensation claim costs. Therefore, it is recommended that the City consider developing and implementing a formal return to work program applicable to all departments.
2. It is recommended that the formalized program include written guidelines incorporating roles and responsibilities for all parties listed above. Senior City management should demonstrate visible support for the program.

4-h. Proper File Documentation/Maintenance

Findings

- The sample of claim files reviewed contained very little documentation of the claim adjusters' activities.
- Claim action plans were not seen in the files.
- Improved documentation was seen in the files during the past year, due to the claim manager's intervention.
- In addition, medical bills are not kept in the claim files. Some medical reports are contained in the files, but it was not possible to determine the medical costs associated with the claims reviewed.
- The audit team also noted several instances where two and three different occurrences and claims were mixed into one file folder.

Best Practices

- *Claim files are generally documented in such a way that the activities, analyses, sequence of claim handling and claim disposition plan is clear to anyone reading the file. When a claim file is documented in this manner, it is possible to pick up a file, read it, and know what has been done, how much has been spent, and what remains to be done.*
- *A clear plan of action is maintained in order to demonstrate progress toward claim resolution.*
- *Each occurrence is handled individually and separate claim files are maintained.*
- *If an employee is treating for multiple occurrences, the treatments can be coordinated.*

File Documentation/Maintenance Recommendations

1. The claim manager has recognized that this is a target area for improvement and, as noted previously, there has been some improvement in file documentation as a result of his efforts. It is recommended that all adjusters be trained in proper claim file documentation, and that documentation of each activity, along with action plans, be required in each claim file from this point forward.
2. It is also recommended that after sufficient training, evaluation of proper claim file documentation should be included in the claim adjusters' performance evaluation.
3. In addition, it is recommended that every occurrence be maintained as a separate claim file and be handled individually. However, all open claims for one employee should be handled in a coordinated manner, by the same claim adjuster.

4-i. Proper Medical Management/Cost Containment

Findings

- The sample claim files reviewed, revealed that most medical management and cost containment is done by vendors.
- Vendors do all medical case management, though no formal criteria for vendor referral could be discovered. It appears that each adjuster uses their own set of informal criteria to make referrals for case management.
- In addition, the claim files reviewed did not demonstrate evidence of adjuster management of vended medical case management services and costs.
- Medical bills are re-priced to the state fee schedule by vendors, but documentation of the costs and savings associated with this service was not seen in the claim files reviewed.
- It was also noted in the files reviewed that vendors sometimes arrange Independent Medical Examinations (IMEs). In these situations, the vendors charge the City for setting up the IME and then interpreting the results.
- In those claim files reviewed where the claim adjusters set up an IME, a form letter was used which gave little direction to the IME physician. The Claim Department's medical resource, a doctor, helps the claim representatives interpret the results of the IMEs.

Best Practices

- *In a best practice operation, formal criteria for referral to medical case management and vocational rehabilitation services are in place and used consistently by all adjusters.*
- *Specific criteria also exist to assist adjusters in managing vendor services and the associated costs. This ensures that vendor services are used in a cost-effective manner, which has an impact on employee return to work and overall claim resolution.*

- *The purpose of medical management is to ensure that an injured employee receives appropriate treatment for the type of injury sustained. The goal is to have the injured worker returned to health as quickly as possible. The secondary result of this oversight is cost savings due to timely return to work.*
- *In situations where there is disagreement between the Claim Department, treating providers and other medical resources regarding the course of treatment or the employee's ability to return to work, an Independent Medical Examination (IME) can be used to render an opinion regarding the specific issues in question. It is common practice for claim adjusters to schedule these routine IMEs.*
- *In cases where specific treatment issues are in question, medical resources (both in-house and vendor) can be used to assist with the identification of a specific provider to conduct the examination, as well as with the actual coordination of the IME to ensure that the critical medical issues are addressed.*

Medical Management/Cost Containment Recommendations

1. It is recommended that specific criteria be established for vendor referral and management by adjusters.
2. The claim representatives should receive formal training in medical management, and in the use of Independent Medical Examinations.
3. It would also be beneficial to develop specific procedures for use by the adjusters in these areas, which would enable them to perform basic medical management currently performed by vendors. This process, in addition to specific vendor referral and management criteria, would ensure the cost-effective use of vendor services.
4. It is recommended that training for adjusters encompass at least the following areas: medical terminology, medical treatment protocols and disability duration.
5. The Claim Department doctor's current involvement is a strength, and his services should be used on each indemnity case to assist the claim adjusters with their assessment of the injury and disability. A formal process should be developed and implemented to strengthen the use of the doctor as an ongoing resource to assist the adjusters in managing the medical aspects of the claims.

4-j. Supervisory Direction Documented

Findings

- ▲ This aspect of the claim files reviewed reflects significant improvement over the past 12 months. It is obvious that the workers' compensation claim manager understands the elements necessary for good claims management. The claim file sample reviewed, reflected that a number of files had been recently reviewed by the claim manager, with clear analysis and claim direction provided as a result of his review. The claim manager's reviews demonstrate his significant experience in workers' compensation claims management.
- ▲ In addition, the team did not find documentation of follow up to ensure that his recommendations were carried out. This may be a result of the current pending workload in the unit.

Best Practices

- ■ *Supervisor/manager reviews are typically done on each new claim upon receipt.*
- ■ *At regular intervals afterward (30 days, 90 days, etc.), further reviews are done to ensure proper claim direction and timely execution of prior supervisory recommendations.*
- ■ *The supervisor or manager is responsible working with the adjuster to keep the claim on track and progressing toward closure.*

Supervisory Direction Recommendations

1. It is recommended that the manager review all new claims upon receipt.
2. A diary system (possibly linked to a RMIS system) should be instituted to allow the manager to review ongoing claims on a regular basis in order to provide direction and insight to the adjusters.
3. In addition, it is recommended that specific “red flags” be developed for the adjusters to identify potential problem issues requiring immediate supervisory review.

4-k. Timely Payment of TTD/PPD/Bills

Findings

- ▲ Based on the claim file sample reviewed, no evidence of late payments was found.
- ▲ It was difficult to evaluate the timeliness and accuracy of payments however, because they are not paid directly by claim staff. Payments are made through the City's voucher/payment system, and are not systematically recorded in the claim file.

Best Practices

- ■ *Both medical and indemnity payments are normally made by the claim representatives through a desktop RMIS system with payment capabilities.*
- ■ *Alternatively, medical bill payments can be made through a separate medical bill processing system, which links with the adjusters' desktop RMIS system.*
- ■ *Michigan workers' compensation law requires that payment of both medical bills and indemnity (lost time) be made within specified timeframes.*
- ■ *The law requires that the first indemnity payment be made on the 14th day following the first day of disability, or on the 8th day if the disability is expected to last more than 14 days.*
- ■ *The law also requires that medical bills be paid within 30 days of receipt, or that the provider be notified of payment delay, and the reason for the delay within that timeframe.*

Timely Payment Recommendations

1. It is suggested that the City review the current voucher/payment system and consider alternatives.
2. Any alternative considered should simplify the payment process for both medical bills and indemnity payments.
3. Alternatives considered should also facilitate claim adjuster control over the timeliness of all claim payments. Due to the internal procedures of the City, it may not be possible to change this form of payment at this time.

4-l. Diary Maintained/Aggressive Action Plan Noted

Findings

- ▲ No formal diary system was noted in the claim files reviewed.
- ▲ Also, no evidence of adjuster action plans was found in the claim file sample reviewed.
- ▲ The audit team noted long gaps between actions in a file; well-documented strategies and action steps for claim resolution were not seen.
- ▲ It is also significant that of the claim file sample reviewed the average length of time a claim was open was 49.8 months.

Best Practices

- ■ *Claims are typically diaried on a periodic basis by the adjuster to ensure that file activity continues to bring the claim toward closure. Diaries are set based upon the specific claim situation, but at least every 30-90 days.*
- ■ *A specific plan of action is also developed, activity is monitored within the framework of the action plan, and the plan is modified as claim circumstances change. The action plan outlines a step by step procedure to bring the claim to conclusion.*
- ■ *If it is determined that the claim is not compensable, the plan of action is developed to defend the claim.*

Diary/Action Plan Recommendations

1. It is recommended that the adjuster develop and document an action plan for claim resolution on every claim file.
2. The plan of action should outline the specific steps that will be taken to bring the claim to conclusion, and the estimated timeframes associated with each step. These actions will help to ensure that all file activity continues to drive the claim toward closure and will ultimately help to reduce the average claim duration.
3. It is also recommended that a diary system be established to ensure periodic review of the claim and facilitate progress toward claim closure.
4. It is beneficial to have the claim manager review the claim adjuster's action plan for each claim file at periodic supervisory review (diary) dates.

4-m. Activity Check/Surveillance Appropriate/Authorized

Findings

- ▲ The sample of claim files reviewed demonstrated that activity checks and surveillance were underutilized.
- ▲ It was found that "Alive and Wells" were done on some files. However, these were done merely to see if the person is alive, and do not constitute activity checks to help determine the extent of an injured employee's activity.

Best Practices

- ■ *Activity checks and surveillance are tools used to verify the level and nature of an injured employee's activity and the extent to which the employee's disability affects his or her level of activity.*
- ■ *Activity checks are visits to an injured employee's neighborhood to view the employee's home and speak with neighbors about the employee's regular pattern of activity.*
- ■ *Activity checks are typically limited in duration, lasting only long enough for the investigator to gather sufficient information to create a picture of the employee's regular level of activity.*
- ■ *Surveillance is a more formal and costly observation of an injured employee's activity and movements over a period of several days. They are performed by an investigator who remains in an injured employee's neighborhood for a considerable amount of time, and may follow the employee when he or she leaves the home.*
- ■ *Surveillance may include videotaping of an injured employee's activities.*
- ■ *Both activity checks and surveillance are used when there is a suspicion that an injured employee may be exaggerating the severity of an injury.*
- ■ *Both tools are used to aid in the defense of a claim.*

Activity Check/Surveillance Recommendations

1. It is recommended that the claim adjusters be trained in the use of activity checks and surveillance. This training should focus on the nature of these tools, the differences between them, indications for the use of each tool and the associated costs.
2. Specific "red flags" should be established to assist adjusters in making appropriate referrals for both activity checks and surveillance.

4-n. Appropriate Litigation Management

Findings

- ▲ The sample of files reviewed by the audit team, as well as interviews with both claims and legal staff, revealed that once a claim goes into litigation, the Legal Department assumes complete control. Little evidence of communication between the two departments was seen in the claim files reviewed, but some indication of recent improvement was evident due to claim manager's efforts.
- ▲ The Claim Department currently has no settlement authority. All claim settlement resides with the Legal Department. Several files contained memos written by the claim manager evaluating the settlement value of the claim upon referral to Legal. In these cases, we were unable to determine if the claim manager's evaluations affected settlement negotiations by the Legal Department.

Best Practices

- ■ *Claim adjusters and the claim manager typically handle settlement of routine claims.*
- ■ *Legal staff is used to handle cases in litigation, settlement involving litigated cases and those claims where settlement is appropriate, but complex legal issues are involved.*
- ■ *Definition of roles in this fashion ensures the application of legal expertise in litigation situations where such expertise will yield results.*

Litigation Management Recommendations

1. It is recommended that the roles and responsibilities of the Claim and Legal Departments be redefined with respect to routine claim settlement and litigated claims. Such a redefinition of roles may help to reduce the Legal Department backlog and focus their efforts on those claims where their legal expertise is most beneficial.
2. In addition, processes should be developed, trained and implemented which create a partnership between the Claim Department and Legal Department regarding claim disposition.
3. A formal set of instructions for file transfer and disposal should be implemented.
4. Recurring communications on the status of the litigated claim files should be required, including regular face-to-face meetings between the claim adjusters and legal staff. Strategies such as claim roundtables should be considered, with participation from both departments. Specific claims could be discussed to develop a joint strategy for settlement and or litigation

NOTE: *See the Legal Review Section of this report for the results of an interview with the Assistant Chief Corporation Counsel.*

4-o. Compliance with State Forms/Manual

Findings

- ▲ The sample of claim files reviewed demonstrated proper use of state forms. The forms are filed with the state as mandated by law.
- ▲ The benefit calculations on the files reviewed appear to be properly done.

Best Practices

- ■ *Proper forms are used and filed as the law specifies.*
- ■ *Benefit calculations must also conform to the requirements of the law.*

Compliance Recommendations

1. In order to ensure ongoing compliance in this area, it is recommended that the claims manager review each claim for compliance with state laws as part of ongoing routine supervisory review.

4-p. Settlement Amounts Proper/Timely

Findings

- The Legal Department handles all cases that are settled via lump-sum settlement. The claim files reviewed showed little evidence of input from the claim adjusters in these situations. It was noted in a number of files that the claim manager had written a memo to Legal giving his opinion of the value of the case. These memos are well written and the cases are evaluated well. Legal has the authority to settle the case at that point.
- The files reviewed indicated that the claim adjusters properly close files without lump-sum settlements for disability.
- There was no pattern of overpayments seen in the claim files reviewed.
- It appears that structured settlements are rarely used to help close a case.

Best Practices

- *When a claim is considered for settlement, it is investigated fully and then evaluated by the claim adjuster.*
- *Claim adjusters have designated dollar limits of authority to settle a claim. If the value of the claim is within the claim adjuster's level of financial authority, the claim adjuster can settle the case. If not, the claim adjuster would request authorization from the claim manager, who has a higher level of settlement authority.*
- *If a claim is litigated, the claim adjuster and the Legal Department would agree on a settlement value and a strategy for claim disposition. Structured settlements are used as a tool to close cases.*

Settlement Amounts Recommendations

1. It is recommend that levels of settlement authority be established for the claim adjusters and the claim manager based on experience and skill.
2. Claim adjusters should be authorized to settle routine cases (where no litigation issues exist) within their financial authority without Legal involvement. This will also reduce Legal case backlog, as well as adjuster backlog.
3. Adjusters should receive formal training on the proper methods of establishing settlement values, developing structured settlements, and settlement negotiation.
4. The Claim Department can assist the Legal Department in evaluating and negotiating cases. Under the direction of the claim manager, Legal and the Claim Department can agree on a settlement figure and the parameters for negotiating the case. The Claim Department can then attempt to settle cases that the Legal Department and the Claim Department feel should be settled.
5. Structured settlements should be used as a tool to help settle cases.

5. Litigation Process Review

The following findings and recommendations are based on information obtained during an interview with the Assistant Chief Corporation Counsel, City of Detroit, Labor/Workers' Compensation Section, as well as information obtained from the review of the workers' compensation adjusters' claim files.

The scope of this review did not include an audit of the attorneys' claim files. The comments in the Recommendations sections are based upon workers' compensation best practices and industry standards.

5-a. Referrals to Labor/Workers' compensation Section from Risk Management

Findings

- ▲ According to the Assistant Chief Corporation Counsel, the workers' compensation referrals to Legal vary in the appropriateness of the referral. When a claim is "in dispute," the adjusters are generally quick to refer the case, and those referrals are generally appropriate.
- ▲ When a claim is a "cut-off" case, there are times when the adjusters have acted independently without obtaining an opinion from Legal.
- ▲ Legal staff has also observed a problem with the rate calculation when the adjusters are doing a cut-off.
- ▲ When found rate calculation errors are referred to Risk Management.
- ▲ It is perceived that some of the inaccurate rate calculations appear to be due to Payroll providing inaccurate information.
- ▲ It was also learned that at times the City's attorneys are asked by the adjusters to perform the rate calculations.
- ▲ Clearly defined criteria for referral to Legal was not apparent.
- ▲ In addition, the roles and responsibilities of both Claims and Legal staff regarding both claims "in dispute" and "cut off" cases are not clear.

Best Practices

- ■ *Specific criteria for referral to Legal are clearly documented, and adherence to this process is incorporated into claim adjuster evaluations.*
- ■ *Roles and responsibilities of both Claim and Legal staff are clearly defined, and these roles may vary depending on the specific type of claim situation requiring Legal assistance (e.g., "in dispute" vs. "cut-off").*
- ■ *Additionally, the information required in the file when referred to Legal is also generally well defined. Often, this takes the form of a "litigation checklist" or other type of referral form.*

Litigation Referral Recommendations

1. The Claim and Legal Departments should work together to develop guidelines for referral to Legal. These guidelines should be well documented, and these written guidelines should be provided to the adjusters.
2. The Legal and Claim Departments should jointly conduct training for the adjusters regarding when a file should be referred to the Legal Department.
3. Suggested "red flags" for Legal referral include multiple claims by the same employee; severity of the injury that is not consistent with the incident; stress related claims, etc.
4. Legal and Claims should collaborate to ensure that all necessary information is available when a claim is referred to Legal.
5. It is recommended that the Legal staff develop and provide written instructions and formal training to the adjusters regarding the information needed when referring the file to Legal. The claims files should be thoroughly documented to assure that the attorneys have all of the information needed.
6. It is also recommended that specific written guidelines and training be provided to the adjusters regarding the handling of "cut-offs."
7. Detailed roles and responsibilities for this type of claim should be documented, and the process should be evaluated jointly on a periodic basis by the Claim and Legal Departments.
8. The process of rate calculation should be reviewed with the adjusters to identify any problem areas (e.g., difficulty getting information from payroll, etc.).
9. Written rate calculation procedures should be established, and training provided to the adjusters, if needed.

5-b. Communication Between Legal & Risk Management

Findings

- Both Legal and Claim staff reported communication difficulties between the two departments. Both the Workers' Compensation Manager and the Assistant Chief Corporation Counsel stated the same concern independently of one another: the adjusters do not keep the attorneys informed, and the attorneys do not keep the adjusters informed of file activities.
- Systemic issues have contributed to development of the reported communication issues. It takes days for the Legal Department to have a memorandum dictated, typed and then delivered to Risk Management. It has only been very recently that the Legal Department has had e-mail installed enabling the two departments to communicate electronically.
- In the past, the attorneys did not send file material to the adjusters. Legal staff has now been directed to send copies of Independent Medical Examinations and settlement demands to the adjusters.
- Both the Claim and Legal Department reported a lack of telephone communication between the two departments. The claims adjusters generally do not document phone calls that they make or receive; therefore, it is difficult to determine the frequency or substance of the phone calls made to or received from Legal.
- The audit team was advised that the Legal staff does not know whether the adjusters have guidelines regarding handling of information marked "Attorney Privileged and Confidential." We were unable to see how this information was handled in any of the files reviewed.
- It also appears that roles and responsibilities for sending correspondence regarding legal matters are not well defined. Legal reported that at times the claims adjusters send letters to claimants and medical providers regarding legal issues, but the Legal Department has not reviewed the letters. A concern was expressed by Legal regarding the level of detail included in letters sent without Legal's review.
- The Assistant Chief Corporation Counsel stated that the Legal Department is starting to work on developing form letters that the adjusters can use. He has noticed an improvement in the letters sent by the adjusters since Legal has started to give them guidance in this area and since the two departments have started to have quarterly meetings.

- ▲ Quarterly meetings with all the adjusters and all the attorneys are now being held to discuss workers' compensation in general and specific issues that individual adjusters and attorneys may have. This is a positive movement towards improving communication.

Best Practices

- *Roles, responsibilities, and communication protocols are clearly defined. This includes specific items regarding when the Legal and Claim Departments are expected to communicate with other parties, and when each is authorized to act independently, and what types and the content of correspondence generated by both types of staff.*
- *The claim file is thoroughly documented reflecting both adjuster and attorney activity, and the file includes copies of all correspondence, reports and legal documents produced and received by both Claim and Legal staff.*
- *Form letters are commonly used to address certain types of claim and legal situations.*
- *Regular, periodic meetings between Claim and Legal staff (even outside counsel) are regularly held to develop strategies for claim resolution.*

Communication Recommendations

1. Continue the current process of having Legal develop form letters to be used by the adjusters.
2. It is further recommended that the Claim and Legal Departments jointly develop training to ensure that the adjusters are properly trained in how and when to use the form letters.
3. Clarification is needed to determine the level of responsibility an adjuster has when a file is referred to the Legal Department. Roles, responsibilities and communication protocols should be clearly defined.
4. Now that e-mail is in place in the Legal Department, both the Claim and Legal Departments should be required to communicate using this system. The level of communication should improve if this occurs.
5. It is recommended that when there is an e-mail communication, a copy of the document should be printed and placed in the file.
6. The adjusters should also be instructed to mark copies of all forms of communication from the attorneys as "Privileged and Confidential" when placing it in the claim file.
7. Continue the recent practice of quarterly meetings between the Claim and Legal Departments. Consider whether or not these meetings should be held monthly to establish clarification of roles, responsibilities, process and communication between these departments. These meetings can be a valuable tool towards improving communication and can also be useful in identifying areas where written policies; procedures and training are needed.
8. It is recommended that minutes of the meetings be written and distributed to all participants.
9. Provide training to the adjusters on the need to retain documents marked "Confidential." This training is important to ensure that the adjusters understand the importance of not distributing these documents to other parties.

5-c. Claims Management

Findings

- The Assistant Chief Corporation Counsel advised that per the City Charter when a file is in litigation the Law Department "controls the file." At that point the adjuster is considered to be a support person. Because the Legal Department is controlling the file, the communication level that is needed and the delineation of responsibilities between the attorneys and the adjusters is not clear. Both the Workers' Compensation Manager and Assistant Chief Corporation Counsel expressed concern regarding who should be responsible for claim functions.
- The audit team was also advised that several methods are used to evaluate claims for settlement. An attorney may evaluate a claim and then draft a summary and recommendation for the Assistant Chief Corporation Counsel to review. Legal reported that this information is also forwarded to the workers' compensation manager for his opinion of the settlement recommendation. Another method of settlement evaluation used is for the adjuster to develop a settlement recommendation and send it to Legal for opinion and approval. At times the adjuster's memo is sent to the Law Department without the file. In these instances, the attorneys must then request the file information creating delays.
- The claim file sample reviewed also revealed that the workers' compensation claims manager would sometimes evaluate claims for settlement and send a memo to Legal. The protocols and timeframes for settlement evaluation, response by Legal and the subsequent authorization and case disposition is unclear.
- Based on the audit team's review of the claim files currently in litigation, it was difficult to determine authority levels and protocols for settlement evaluation and negotiation. Both the Claim and Legal Departments expressed frustration with the current settlement processes. The issue of the department responsible for "settlement authority" and "settlement approval" is very confusing. This issue was not well documented in the claim files reviewed. It appears that some delays in resolving settlements appears to be due to communication difficulties between the Legal and Claim Departments on how to resolve the case rather than with difficulty in communicating with the claimant's attorney.

Best Practices

- *Best Practices typically have the workers' compensation adjuster as the manager of the file throughout the litigation process.*
- *In addition, best practices often include a Litigation Committee, established to evaluate cases for settlement value and ultimate case exposure. The Litigation Committee evaluates the odds of prevailing in litigation, identifies cases that should be evaluated for a pre-litigation offer and tracks the results of settlement offers.*
- *Clearly defined timeframes are also established, advising at what point a file should be referred to the Committee and the length of time the Committee has to draft a recommendation.*

Claims Management Recommendations

1. It is recommended that the Claim and Legal Departments jointly develop a set of guidelines regarding the roles and responsibilities of attorneys and adjusters when a file is in litigation. The City needs to identify how the its Charter defines a file "in litigation." Obtain clarification of the claim file responsibility that is mandated by the City Charter. It is equally important to clarify and document the circumstances under which responsibility reverts back to the adjuster when a litigated file reaches resolution.
2. When the requirements of the City Charter are clearly defined, it is recommended that the Risk Management and Legal Departments develop a joint plan that describes their respective responsibilities regarding claim management. Risk Management and Legal need to clarify who is responsible for communicating with claimants, supervisors and medical providers in specific situations throughout the course of litigation.
3. It is recommended that the Legal staff develop clear guidelines regarding what information and documents are needed to evaluate a settlement recommendation that comes from the Workers' compensation Department. It is further recommended the Claim and Legal Department work together to develop guidelines and dollar limits regarding settlement authority.
4. It is recommended that a litigation committee be established. While the use of a committee can be time consuming, it may result in quicker claim resolutions than currently seen due to communication issues that exist today between the Claim and Legal Departments.

5-d. Workloads of Attorneys

Findings

- The audit team was advised that in addition to the Assistant Chief Corporation Counsel, there are four attorneys currently assigned to handle workers' compensation cases.
- The Assistant Chief Corporation Counsel does not have a caseload of workers' compensation files, but has supervisory responsibility for all files in litigation. He also practices labor law within the unit.
- The four workers' compensation attorneys handle a total of 1,000 claim files. Based on this interview it could not be determined what percent of the 1,000 claims are "active" as opposed to those claims that have reached a resolution and are ready to be or should have been closed.
- The Law Department generally only refers cases to outside firms when there is a conflict, or it is an exceptionally complex case. The Assistant Chief Corporation Counsel stated that the number of petitions has been increasing and if this trend continues, it might be necessary to use outside counsel more frequently.
- We were also advised that the attorneys have been charged with developing relationships with the workers' compensation mediators, and at least one of the attorneys is present at the Bureau everyday. The Assistant Chief Corporation Counsel feels this has been helpful in achieving improved outcomes at hearings.

Best Practices

- *Attorneys in wage loss states in private practice recommend a caseload that does not exceed 60 to 70 claims.*
- *In addition, even in situations where in-house counsel exists, outside counsel is used in well-defined situations.*
- *Clear guidelines for when a case should be referred to outside counsel is also in place, along with protocols for management of outside attorneys.*
- *Outside counsel often serves as a resource for information on changes and trends in workers compensation.*

Attorney Workload Recommendations

1. The attorney caseloads at 250 per attorney are exceptionally and unrealistically high. It is recommended that a review of the listed cases be conducted to determine whether a number of them may be close to closure. Strategies to close the cases identified should be developed and implemented in order to conclude them as quickly as possible and to reduce caseload.
2. An additional strategy to reduce the number of cases is to use outside counsel on a very limited and controlled basis to handle some of the excessive workloads of in-house attorneys.
3. Outside counsel could also be used to review cases that have had settlement discussions to determine if a number of them could be closed in a timely manner. Specific protocols and guidelines should be developed if these strategies are considered.
4. It is further recommended specific guidelines be developed for the adjusters regarding how and when to refer cases to outside counsel.
5. Adjusters should be fully trained in the use of these guidelines and in management of outside legal staff.
6. It is also recommended that outside counsel not be used until such guidelines are developed and the adjusters are fully trained in their use.
7. Roles and responsibilities of adjusters and attorneys should also be clearly delineated prior to implementing a process for referral to outside counsel.
8. Outside counsel should also be considered as a resource to provide periodic training to both the Legal and Risk Management Departments regarding workers' compensation trends and changes in Michigan law.